FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043943

Facility Name: TERRACE NURSING HOME

Address: 1615 SUNSET AVE. (Number) WAUKEGAN (City) 60087 (Zip Code)

County: LAKE

Telephone Number: (847) 244-6700 **Fax #** (847) 244-7925

IDPA ID Number: 36-4228300

Date of Initial License for Current Owners: 07/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	65	Skilled (SNF)	65	23,790	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,300	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	42,090	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	530	936	3,975	5,441	8
9	SNF/PED					9
10	ICF	21,970	10,992	549	33,511	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,500	11,928	4,524	38,952	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.54%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [ ] If YES, enter number of beds certified 22 and days of care provided 3,975

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,428	10,202	7,531	190,161		190,161		190,161			1
2	Food Purchase		154,166		154,166	(4,648)	149,518	(1,103)	148,415			2
3	Housekeeping	154,672	12,051		166,723		166,723		166,723			3
4	Laundry	59,578	13,227	2,297	75,102		75,102	108	75,210			4
5	Heat and Other Utilities			95,920	95,920		95,920	286	96,206			5
6	Maintenance	51,565	19,169	33,070	103,804		103,804	2,958	106,762			6
7	Other (specify):*			11,566	11,566		11,566	49	11,615			7
8	**TOTAL General Services**	438,243	208,815	150,384	797,442	(4,648)	792,794	2,298	795,092			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	1,927,761	81,324	9,259	2,018,344		2,018,344		2,018,344			10
10a	Therapy	36,426		1,967	38,393		38,393		38,393			10a
11	Activities	73,117	8,364	1,776	83,257		83,257		83,257			11
12	Social Services	46,475		4,500	50,975		50,975		50,975			12
13	Nurse Aide Training											13
14	Program Transportation			325	325		325		325			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,083,779	89,688	37,327	2,210,794		2,210,794		2,210,794			16
	C. General Administration											
17	Administrative	73,500		34,500	108,000		108,000	(22,138)	85,862			17
18	Directors Fees											18
19	Professional Services			36,035	36,035		36,035	4,198	40,233			19
20	Dues, Fees, Subscriptions & Promotions			39,741	39,741		39,741	(25,273)	14,468			20
21	Clerical & General Office Expenses	86,684	16,057	46,645	149,386		149,386	(5,609)	143,777			21
22	Employee Benefits & Payroll Taxes			466,810	466,810	4,648	471,458		471,458			22
23	Inservice Training & Education							43	43			23
24	Travel and Seminar			2,659	2,659		2,659		2,659			24
25	Other Admin. Staff Transportation			9,808	9,808		9,808	437	10,245			25
26	Insurance-Prop.Liab.Malpractice			57,771	57,771		57,771	350	58,121			26
27	Other (specify):*			46,224	46,224		46,224	(42,863)	3,361			27
28	**TOTAL General Administration**	160,184	16,057	740,193	916,434	4,648	921,082	(90,855)	830,227			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,682,206	314,560	927,904	3,924,670		3,924,670	(88,557)	3,836,113			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: TERRACE NURSING HOME **#0043943** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		1,591	
			0	7,531
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,297	
			0	2,297
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,183	
	ELECTRICITY		37,909	
	WATER		15,828	
	CABLE TV - LOBBY		1,000	
			0	95,920
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,620	
	PAINTING & DECORATING		473	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,263	
	ELEVATOR MAINTENANCE & REPAIR		16,777	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,619	
	FIRE SERVICE		3,318	
			0	
			0	
			0	33,070
7	**OTHER**			
	SCAVENGER		8,866	
	SECURITY SERVICE		2,700	11,566
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	19,500	19,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	626	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,784	
	PHARMACY CONSULTANT	XVIII B 39-2	4,849	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	9,259
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,140	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	827	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,967
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,776	
			0	1,776
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,500	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,500
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number TERRACE NURSING HOME #0043943 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		325	325
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	34,500	34,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,246	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	21,789	
			0	36,035
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,955	
	EMPLOYEE WANT ADS	XIX F	1,563	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	5,074	
	LICENSES & PERMITS	XIX F	6,779	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	15,187	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,243	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	440	39,741
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		25,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	79	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		21,064	
	MESSENGER SERVICE		0	
			0	46,645

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	201,654	
	UNEMPLOYMENT COMPENSATION	XIX D	16,734	
	WORKERS COMPENSATION INSURANCI	XIX D	75,725	
	HOSPITALIZATION INSURANCE	XIX D	153,718	
	EMPLOYEE BENEFITS - OTHER	XIX D	438	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	18,541	
	CHICAGO HEAD TAX	XIX D	0	466,810
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	2,659	
	TRAVEL	XIX G	0	
			0	
			0	2,659
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,808	9,808
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		57,771	57,771
27	**OTHER**			
	BAD DEBTS	VI 24	46,224	
				46,224

GRAND TOTAL COLUMN 3 OTHER 927,904

TERRACE NURSING HOME
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	154,166
LESS SALES TAX	(1,103)
NET FOOD	153,063
TOTAL PATIENT CENSUS	38,952
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	116856
ADD # EMPLOYEE MEALS/DAY	10
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	3660

PATIENT MEALS	116856
ADD EMPLOYEE MEALS	3660
TOTAL MEALS/YEAR	120516
NET FOOD	153063
DIVIDE TOTAL MEALS/YEAR	120516
COST PER MEAL	1.27
TIME EMPLOYEE MEALS	3660
EMPLOYEE MEAL RECLASSIFICATION	4648

Facility Name & ID Number TERRACE NURSING HOME #0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			68,298	68,298		68,298	43,843	112,141			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,382	48,382		48,382	164,271	212,653			32
33	Real Estate Taxes			74,233	74,233		74,233	1,226	75,459			33
34	Rent-Facility & Grounds			109,031	109,031		109,031	(109,031)				34
35	Rent-Equipment & Vehicles			32,481	32,481		32,481	3,138	35,619			35
36	Other (specify):* **RENT - IME**			8,970	8,970		8,970	(8,970)				36
37	**TOTAL Ownership**			341,395	341,395		341,395	94,477	435,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		135,799	183,202	319,001		319,001		319,001			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,136	63,136		63,136		63,136			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		135,799	246,338	382,137		382,137		382,137			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,682,206	450,359	1,515,637	4,648,202		4,648,202	5,920	4,654,122			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,964)	30		9
10	Interest and Other Investment Income	(296)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,103)	2		13
14	Non-Care Related Interest	(47,851)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(79)	21		18
19	Entertainment		20		19
20	Contributions	(2,743)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,224)	27		24
25	Fund Raising, Advertising and Promotional	(7,955)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(15,187)	20		28
29	Other-Attach Schedule	(1,030)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (133,432)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	139,352		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 139,352		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,920		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

TERRACE NURSING HOME

ID# 0043943

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 970	6	1
2	PHILIP ESFORMES - MANAGEMENT FEE	(2,000)	17	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,030)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,103)	0	0	0	0	0	0	0	0	0	0	(1,103)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	108	0	0	0	0	0	0	0	0	108	4
5	Heat and Other Utilities	0	0	0	286	0	0	0	0	0	0	0	286	5
6	Maintenance	970	0	1,265	723	0	0	0	0	0	0	0	2,958	6
7	Other (specify):*	0	0	19	30	0	0	0	0	0	0	0	49	7
8	**TOTAL General Services**	(133)	0	1,392	1,039	0	0	0	0	0	0	0	2,298	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(2,000)	(24,323)	4,185	0	0	0	0	0	0	0	0	(22,138)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	99	4,054	45	0	0	0	0	0	0	0	4,198	19
20	Fees, Subscriptions & Promotions	(25,885)	0	612	0	0	0	0	0	0	0	0	(25,273)	20
21	Clerical & General Office Expenses	(79)	4,769	(10,425)	126	0	0	0	0	0	0	0	(5,609)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	43	0	0	0	0	0	0	0	0	43	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	137	300	0	0	0	0	0	0	0	0	437	25
26	Insurance-Prop.Liab.Malpractice	0	0	200	150	0	0	0	0	0	0	0	350	26
27	Other (specify):*	(46,224)	657	2,704	0	0	0	0	0	0	0	0	(42,863)	27
28	**TOTAL General Administration**	(74,188)	(18,661)	1,673	321	0	0	0	0	0	0	0	(90,855)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,321)	(18,661)	3,065	1,360	0	0	0	0	0	0	0	(88,557)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,964)	0	160	875	53,772	0	0	0	0	0	0	43,843	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(48,147)	0	0	1,138	211,280	0	0	0	0	0	0	164,271	32
33	Real Estate Taxes	0	0	0	1,226	0	0	0	0	0	0	0	1,226	33
34	Rent-Facility & Grounds	0	0	0	0	(109,031)	0	0	0	0	0	0	(109,031)	34
35	Rent-Equipment & Vehicles	0	397	2,655	86	0	0	0	0	0	0	0	3,138	35
36	Other (specify):*	0	0	0	(8,970)	0	0	0	0	0	0	0	(8,970)	36
37	TOTAL Ownership	(59,111)	397	2,815	(5,645)	156,021	0	0	0	0	0	0	94,477	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(133,432)	(18,264)	5,880	(4,285)	156,021	0	0	0	0	0	0	5,920	45

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	50			EMI ENTERPRISES	LINCOLNWOOD	CONSULTING
PHILLIP ESFORMES	50			EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
				EKS MGMT.	LINCOLNWOOD	HOME OFFICE
		SEE ATTACHED SCHEDULE				RENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 32,500	EMI ENTERPRISES		$	$ (32,500)	1
2	V	17	OFFICERS SALARY				8,177	8,177	2
3	V	19	ACCOUNTING FEES				99	99	3
4	V	21	TOTAL OFFICE				4,769	4,769	4
5	V	25	TRANSPORTATION				137	137	5
6	V	26	INSURANCE						6
7	V	27	EMPLOYEE BENEFITS				657	657	7
8	V								8
9	V	35	AUTO LEASE				397	397	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 32,500			$ 14,236	$ * (18,264)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 25,500	EKS MANAGEMENT, INC.		$	$ (25,500)	15
16	V	4	HOUSEKEEPING SALARIES				108	108	16
17	V	6	PAINTING/DECORATING				1,265	1,265	17
18	V	7	SCAVENGER				19	19	18
19	V	17	C F O SALARY				4,185	4,185	19
20	V	19	PROFESSIONAL FEES				4,054	4,054	20
21	V	20	WANT ADS / BCK GRND CKS				612	612	21
22	V	21	OFFICE				15,075	15,075	22
23	V	23	SEMINARS				43	43	23
24	V	25	TRANSPORTATION				300	300	24
25	V	26	INSURANCE				200	200	25
26	V	27	EMPLOYEE BENEFITS				2,704	2,704	26
27	V	30	DEPRECIATION (SL)				160	160	27
28	V	35	EQUIPMENT RENT				2,655	2,655	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 25,500			$ 31,380	$ * 5,880	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 8,970	IME REALTY CORP		$	$ (8,970)	15
16	V	5	UTILITIES				286	286	16
17	V	6	REPAIRS & MAINTENANCE				723	723	17
18	V	7	ALARM SERVICE				30	30	18
19	V	19	PROFESSIONAL FEES				45	45	19
20	V	21	OFFICE EXPENSE				126	126	20
21	V	26	INSURANCE				150	150	21
22	V	30	DEPRECIATION (SL)				875	875	22
23	V	32	INTEREST				1,138	1,138	23
24	V	33	REAL ESTATE TAX				1,226	1,226	24
25	V	35	STORAGE FEES				86	86	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,970			$ 4,685	$ * (4,285)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 109,031	THE TERRACE INVESTOR GROUP		$	$ (109,031)	15
16	V	30	DEPRECIATION				53,772	53,772	16
17	V	32	INTEREST				211,280	211,280	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,031			$ 265,052	$ * 156,021	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GEN. PARTNER	ADMINISTRATO	50.00	SEE ATTACHED			SALARY	$ 8,177	17-8	1
2											2
3	AVRUM WEINFELD	C.F.O.	C.F.O.		SEE ATTACHED			SALARY	4,185	17-8	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,362		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	38,955	$ 8,177	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		38,955	99	2
3	21	TOTAL OFFICE	PATIENT DAYS	881,303	14	107,899	87,197	38,955	4,769	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		38,955	137	4
5	26	INSURANCE	PATIENT DAYS	881,303	14				0	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		38,955	657	6
7										7
8	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		38,955	397	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 14,236	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	$ 2,437	$ 2,437	38,955	$ 108	1
2	6	PAINTING / DECORATING	PATIENT DAYS	881,303	14	28,615	28,615	38,955	1,265	2
3	7	SCAVENGER	PATIENT DAYS	881,303	14	429		38,955	19	3
4	17	C F O SALARY	PATIENT DAYS	881,303	14	94,671	94,671	38,955	4,185	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723		38,955	4,054	5
6	20	WANT ADS / BCK GRND CKS	PATIENT DAYS	881,303	14	13,841		38,955	612	6
7	21	OFFICE EXPENSE	PATIENT DAYS	881,303	14	341,059		38,955	15,075	7
8	23	SEMINARS	PATIENT DAYS	881,303	14	984		38,955	43	8
9	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		38,955	300	9
10	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		38,955	200	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		38,955	2,704	11
12	30	DEPRECIATION S/L	PATIENT DAYS	881,303	14	3,617		38,955	160	12
13	35	EQUIPMENT RENT	PATIENT DAYS	881,303	14	60,061		38,955	2,655	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 125,723		$ 31,380	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	312,263	15	$ 9,942	$	8,970	$ 286	1
2	6	REPAIRS & MAINTENANCE	INCOME	312,263	14	25,152		8,970	723	2
3	7	ALARM SERVICE	INCOME	312,263	14	1,056		8,970	30	3
4	19	PROFESSIONAL FEES	INCOME	312,263	14	1,575		8,970	45	4
5	21	OFFICE EXPENSE	INCOME	312,263	14	4,388		8,970	126	5
6	26	INSURANCE	INCOME	312,263	14	5,225		8,970	150	6
7	30	DEPRECIATION (SL)	INCOME	312,263	14	30,446		8,970	875	7
8	32	INTEREST	INCOME	312,263	14	39,619		8,970	1,138	8
9	33	REAL ESTATE TAX	INCOME	312,263	14	42,669		8,970	1,226	9
10	35	STORAGE FEES	INCOME	312,263	14	3,011		8,970	86	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,083	$		$ 4,685	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE TERRACE INVESTOR GROUP
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 53,772	$	1	$ 53,772	1
2	32	INTEREST	DIRECT	1	1	211,280		1	211,280	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 265,052	$		$ 265,052	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LASALLE BANK		X	MORTGAGE	$26,007.00	7/15/03	$ 3,919,674	$ 3,763,971	7/15/28	0.0543	$ 211,280	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				100,000	REVOLV		531	6
7												7
8												8
9	TOTAL Facility Related				$26,007.00		$ 3,919,674	$ 3,863,971			$ 211,811	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11	TERRACE INVESTMENT GROUP										47,851	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 47,851	14
15	TOTALS (line 9+line14)						$ 3,919,674	$ 3,863,971			$ 259,662	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	70,177	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	72,205	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,028	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	72,205	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	74,233	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	50,736	8
2000	52,622	9
2001	62,144	10
2002	70,177	11
2003	72,205	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TERRACE NURSING HOME COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0043943

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-403-011	NURSING HOME	$ 72,204.85	$ 72,204.85
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 72,204.85	$ 72,204.85

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior BRICK Frame MASONRY/STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1989	$ 82,052	1
2					2
3	TOTALS			$ 82,052	3

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112		1989		$ 2,088,222	$ 53,772	31.5	$ 53,772	$	$ 948,335	4
5											5
6											6
7	RELATED PARTY					840		840			7
8											8
	Improvement Type**										
9	DOOR BYPASS ALARM			1998	3,453	89	39	89		538	9
10	BOILER			2000	32,900	1,196	27.5	1,196		5,834	10
11	DOORS AND FRAMES			2000	3,366	123	27.5	123		566	11
12	FIRE DOOR			2000	5,039	183	27.5	183		847	12
13	FIRE DAMPERS			2000	12,123	441	27.5	441		1,966	13
14	NURSING STATION			2001	15,200	553	27.5	553		1,958	14
15	EJECTOR PUMPS			2001	5,898	215	27.5	215		761	15
16	OVER THE BED LIGHTS			2001	6,142	223	27.5	223		790	16
17	FURNISHINGS - FLOORING			2001	81,365	9,373	10	8,137	(1,236)	28,477	17
18	FURNISHINGS - CUBICLE CURTAINS & BLINDS			2001	43,874	5,055	10	4,387	(668)	15,355	18
19	TILING			2002	8,448	307	27.5	307		780	19
20	HOT WATER TANK			2002	8,916	324	27.5	324		824	20
21	REPLACE PARKING LOT			2003	16,980	1,132	15	1,132		1,698	21
22	REPLACE PATIO & REPAIR STAIRS			2003	15,450	1,030	15	1,030		1,545	22
23	FENCE			2003	3,600	240	15	240		360	23
24	EJECTOR PUMPS			2003	8,780	319	27.5	319		492	24
25	5 TON AIR COOLING SYSTEM			2003	25,353	922	27.5	922		1,421	25
26	PANIC ALARM			2003	1,222	44	27.5	44		68	26
27	200 AMP ELECTRICAL PANEL			2003	6,975	254	27.5	254		392	27
28	FLOORING			2004	5,544	109	27.5	109		109	28
29	SLIDING DOOR			2004	9,024	178	27.5	178		178	29
30	BOILER REPAIR			2004	1,308	26	27.5	26		26	30
31	EXPANSION TANKS FOR HOT WATER HEATING SYSTEM			2004	2,134	42	27.5	42		42	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,411,316	$ 76,990		$ 75,086	$ (1,904)	$ 1,013,362	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 365,218	$ 41,870	$ 36,522	$ (5,348)		$ 139,416	71
72	Current Year Purchases	6,750	4,050	338	(3,712)		338	72
73	Fully Depreciated Assets							73
74	IME,EKS,EMI ALLOCATION		195	195				74
75	TOTALS	$ 371,968	$ 46,115	$ 37,055	$ (9,060)		$ 139,754	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,865,336	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,105	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,141	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,964)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,153,116	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		115		$ 109,031			3
4	Additions							4
5								5
6								6
7	TOTAL		115		$ 109,031 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 22,835 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	NURSING FACILITY	01 CHEVY EXP VAN	$	$ 1,417	17
18	NURSING FACILITY	03 ECONOLINE WAGON	686.00	8,229	18
19					19
20					20
21	TOTAL		$ 686.00	$ 9,646	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number TERRACE NURSING HOME

STATE OF ILLINOIS
0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 85,673	$		$ 85,673	1
2	Licensed Speech and Language Development Therapist		hrs			4,486			4,486	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			93,043			93,043	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				121,283		121,283	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): radiology, lab, suppllies						14,516		14,516	13
14	TOTAL			$		$ 183,202	$ 135,799		$ 319,001	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 149,052	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	650,869		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,049		6
7	Other Prepaid Expenses	14,622		7
8	Accounts Receivable (owners or related parties)	281,126		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,182,718	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	197,855		15
16	Equipment, at Historical Cost	523,640		16
17	Accumulated Depreciation (book methods)	(430,527)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSIT	230,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 520,968	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,703,686	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,116,552	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,384		28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	90,381		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,667		31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,205		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTY	113,474		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,528,663	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,528,663	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 175,023	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,703,686	$	48

*(See instructions.)

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (54,883)	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(3,871)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (58,754)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	456,777	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(223,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 233,777	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 175,023	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,043,088	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,043,088	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	61,595	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 61,595	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	296	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 296	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,104,979	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	797,442	31
32	Health Care	2,210,794	32
33	General Administration	916,434	33
	B. Capital Expense		
34	Ownership	341,395	34
	C. Ancillary Expense		
35	Special Cost Centers	319,001	35
36	Provider Participation Fee	63,136	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,648,202	40
41	**Income before Income Taxes (line 30 minus line 40)****	456,777	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 456,777	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,923	6,617	$ 154,911	$ 23.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	22,688	25,721	713,272	27.73	3
4	Licensed Practical Nurses	5,998	6,367	127,287	19.99	4
5	Nurse Aides & Orderlies	81,041	87,769	894,614	10.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,319	3,448	36,426	10.56	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,641	8,140	73,117	8.98	10
11	Social Service Workers	3,274	4,031	46,475	11.53	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,170	21,034	172,428	8.20	15
16	Dishwashers					16
17	Maintenance Workers	4,073	4,131	51,565	12.48	17
18	Housekeepers	17,344	19,677	154,672	7.86	18
19	Laundry	6,679	7,460	59,578	7.99	19
20	Administrator	2,080	2,314	73,500	31.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,220	8,832	86,684	9.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,832	2,024	30,627	15.13	31
32	Other Health Care(specify)					32
33	Other(specify) MDS coordinator	260	260	7,050	27.12	33
34	TOTAL (lines 1 - 33)	188,542	207,825	$ 2,682,206 *	$ 12.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fee	$ 5,940	1-3	35
36	Medical Director	monthly fee	19,500	9-3	36
37	Medical Records Consultant	monthly fee	3,784	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	4,849	10-3	39
40	Physical Therapy Consultant	monthly fee	1,140	10a-3	40
41	Occupational Therapy Consultant		827	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	35	1,776	11-3	44
45	Social Service Consultant	87	4,500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	122	$ 42,316		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses	21	270	10-3	51
52	Nurse Aides	43	355	10-3	52
53	TOTAL (lines 50 - 52)	64	$ 625		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROSE SCHULTS	ADMIN		$ 73,500
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,500

B. Administrative - Other

Description	Amount
EMI ENTERPRISES - MANAGEMENT FEE	$ 32,500
PHILIP ESFORMES, INC - MANAGEMENT FEE	2,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 34,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,567
HEALTH DATA SYSTEMS	DATA PROCESSING	6,162
IVANS	DATA PROCESSING	787
LTC SOLUTIONS	DATA PROCESSING	1,320
MAXXSOURCE	DATA PROCESSING	1,410
KRUPNICK BOKOR	ACCOUNTING	12,600
LARRY SCHWARTZ	LEGAL	1,320
STONE, MCGUIRE, BENJAMIN	LEGAL	812
RICHARD PEELO	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNCERS	UC CONSULTANT	2,557
SEE SCHEDULE ATTACHED		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 36,035

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 75,725
Unemployment Compensation Insurance		16,734
FICA Taxes		201,654
Employee Health Insurance		153,718
Employee Meals		4,648
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		438
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		18,541
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 471,458

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,300
Advertising: Employee Recruitment	1,563
Health Care Worker Background Check	440
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	23,142
TRUST/FRANCHISE/CONTRIB/ETC	2,743
LICENSES & PERMITS	2,479
DUES & SUBSCRIPTIONS	5,074
MGMT CO ALLOCATION	612
TRUST/FRANCHISE/CONTRIB/ETC	(2,743)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,955)
Yellow page advertising	(15,187)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,468

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	2,659
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,659

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	07/99	$ 3,639	3 YRS	$ 1,213	$ 607	$	$	$	$	$	$	$
2	PAINTING/DECORATIN	07/01	5,815	3 YRS	969	1,938	1,938	970					
3													
4													
5													
6													
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20	TOTALS		$ 9,454		$ 2,182	$ 2,545	$ 1,938	$ 970	$	$	$	$	$

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $4,450**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,136**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,648** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees